

HORSE CARRIAGE DRIVER'S MEDICAL APPLICATION

Name of Individual _____

Home Address _____

Date of Birth _____ Age _____ Height: _____ Weight: _____

EYESIGHT:

Snellen Test: Left 20/ _____ Right 20/ _____ Both 20/ _____

Left 20/ _____ Right 20/ _____ Both 20/ _____

HEARING: Right Ear _____ Left Ear _____ Discharge _____

NOSE _____ HANDS _____

LUNGS: Check for asthma , tuberculosis, bronchitis _____

HEART: Cardio-vascular system:

Blood Pressure _____ Systolic _____ Diastolic _____

GENITO-URINARYL

Venereal Disease _____ Wasserman _____ Varicocele _____

Hydrocele _____ Kidneys _____ General _____

HERNIA: (note form) _____ VARICOSE VEINS _____

BONES AND JOINTS: _____

DISABILITIES:(chronic catarrh, sinus, fistula, rectal disease, dutaneous diseases)

ILLNESS AND INJURIES: _____

NEUROTIC TENDENCIES: _____

REMARKS: _____

I hereby certify that this is a true record of the Medical Examination of the above examinee and that I have found him/her qualified physically.

Date of Exam: _____

Medical Examiner: _____

Address of Examiner: _____